Therapeutic Yoga

Name_____

Street_____

City_____ State_____ Zip_____

Home phone_____ Cell phone_____

Email address_____

Date of Birth_____

Have you ever attended a yoga class?_____

In emergency notify_____

Referred by_____

Physician_____Contact Info_____

Current diagnosis_____

Current treatment_____

Do you have any physical limitations?_____

Do you have any injuries?_____

Surgeries (w/dates)_____

Medications_____

Past Medical History, (please check)

___Heart Disease ___High Blood Pressure ___Diabetes ___Stroke ___Cancer

___Seizures ___Thyroid Disease ___ Glaucoma/Detached Retina

You and your family's medical history as it pertains to you_____

_____

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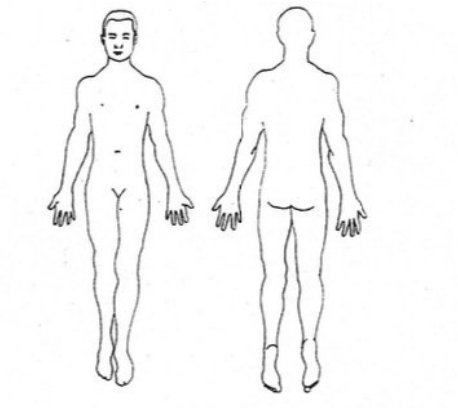
Please circle areas of pain, numbness, or discomfort on the drawing below:



What are you hoping to receive through the practice of Therapeutic Yoga?_____

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Is there anything else you would like me to know?_____

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I _____ (print name) understand that Therapeutic Yoga includes physical movements such as yoga postures, breath work, healing touch (for in-person sessions) and guided meditation. If I experience any discomfort or pain, I will listen to my body, adjust the posture and ask for support from the teacher. I know that I always have permission to come out of a posture at any time.

Therapeutic Yoga is intended to help you increase your level of health and wellness. The instructions and advice presented by your instructor are in no way meant to be a substitute for counseling from your healthcare professional. Consult your healthcare professional before beginning this or any other healthcare program.

Signature of student, parent or guardian_____ Date_____